STATE OF CONNECTICUT

DEPARTMENT OF VETERANS AFFAIRS

287 West Street
Rocky Hill, Connecticut 06067

Dear Veteran,
Thank you for your interest in the Connecticut Department of Veterans' Affairs **OEF/OIF Transitional Assistance Housing Program** for recently returning veterans.

Guidelines for Submitting an Application For
PATRIOTS' LANDING

In order to process the application, each of the following requirements must be met:

1. Enclose a copy(s) of your DD FORM 214 – Certificate of Release or Discharge from Active Duty, which lists your place of entry and place of discharge, date of entry and discharge, record of service, any time lost, and character of service**. If you served more than one period please submit a copy of each DD214 you have received.** If you do not have a DD Form 214 – follow instructions on the enclosed Standard Form 180 (SF180) and mail it to the designated area listed.

2. Proof of Connecticut (CT) Residency – Applicants for this program must be official residents of the State of Connecticut. If your DD214 does not indicate that you deployed from or returned to a Connecticut address, please attach a copy of your Connecticut driver's license.

3. Medical Information – If you are still actively serving in the National Guard or Reserves or were discharged from active duty within the last 12 months, please provide a copy of your last military Periodic Health Assessment (PHA)/physical/MEDPROS profile to include the results of your most recent PPD (TB) test.

   If you are no longer serving or left active duty over 12 months ago, you will need to schedule/complete a physical with your Primary Care Provider at the VA CT Healthcare System which must include a PPD test.

4. Meet and/or agree to all program criteria and house rules.

   For questions concerning the application or application process for PATRIOT'S LANDING, the OEF/OIF Transitional Assistance Housing Program at Rocky Hill, please contact Maria Cheney, Residential Services Director, at (860) 616-3802.

   Fax application to:
   (860) 616-3556

   Mail application to:
   PATRIOTS' LANDING
   OEF/OIF Transitional Assistance Housing Program
   ATTN: Maria Cheney, Residential Services Director
   Department of Veterans' Affairs
   287 West Street
   Bldg. 3, Rm. 104
   Rocky Hill, CT 06067

GENERAL ADMISSIONS CRITERIA

THE FOLLOWING GENERAL STATEMENTS APPLY:

1. A veteran must have received an honorable discharge or general under honorable discharge from the Armed Forces of the United States. Veterans with a dishonorable discharge are not eligible for this program.

2. A veteran must meet all other legal requirements as outlined in the Connecticut statutes.

3. An intake interview conducted by CT DVA staff will be required of all program applicants. Based on that interview, the veteran may be required to provide additional medical, behavioral health, or substance abuse information.

4. All medical care and associated costs is the responsibility of the individual program resident.

Connecticut Department of Veterans' Affairs

Application for Admission to PATRIOTS' LANDING

OEF/OIF Transitional Assistance Housing Program

PLEASE FILL OUT EACH SECTION COMPLETELY (PRINT)

Section 1 - PERSONAL DATA

Last Name _____ First Name _____ Middle Name _____

Others Names/s used _____ Maiden Name (if applicable) _____

Home Address _____ Apt. No. _____ (if applicable)

City _____ State _____ Zip _____ County _____

Home Phone ( ) _____ Work Phone ( ) _____

Cell Phone ( ) _____ Fax # ( ) _____

Pager # ( ) _____ E-mail Address _____

Gender: Male ☐ Female ☐ Are you Spanish, Hispanic, or Latino? ☐ Yes ☐ No

What is your race? (You may check more than one.) (Information is required for statistical purposes only.)

☐ American Indian or Alaska Native ☐ Black or African American

☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander

Social Security Number ___/___/___ Date of Birth (mm/dd/yyyy) ___/___/___

Place of Birth (City and State) _____

State of Connecticut Resident from _____ to _____

Religion _____

Current Marital Status: (Check one) ☐ Married ☐ Never Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Unknown

Number of Dependent Children: _____ List ages: _____

Are you required to pay child support: ☐ Yes ☐ No

Next of Kin, please contact:

Name _____ Phone #1 ( ) _____ Relationship: _____

Phone #2 ( ) _____

In Case of Emergency, please contact:

Name _____ Phone #1 ( ) _____ Relationship: _____

Phone #2 ( ) _____

Name _____ Phone #1 ( ) _____ Relationship: _____

Phone #2 ( ) _____

Section 2 – CURRENT LOCATION

At the time of this application, are you still on active duty ☐ Yes ☐ No

Are you currently living at your home address? ☐ Yes ☐ No

If you are not still on active duty or staying at your home address, where are you staying now?

☐ Shelter ☐ With Family/Friends ☐ Hotel/Motel ☐ Treatment Facility

☐ Temporary Vets Housing ☐ Other (Explain) _____

_____

Name of Current Location _____

Contact Person _____ Title _____ Phone # ( ) _____

Address _____ How Long at this Address? _____

City, State _____

Name _____ **Last 4 Digits of Social Security #** _____

Section 3 – MILITARY SERVICE

Date Entered Active Duty _____ Place of Entry _____
Date of Separation _____ Place of Separation _____
Branch of Service _____ Military Service Number _____
Rank _____ Pay Grade _____
Character of Service □ Honorable □ Under Honorable Conditions □ Medical □ Other (Explain)
Are you currently still serving in the National Guard or Reserves? □ Yes □ No

Did you re-enlist and were issued more than one DD214? □ Yes □ No **If yes, provide copies.**
Name you served under if different from your current name _____
Check yes or no for each of the following questions:
Are you a Purple Heart recipient? □ Yes □ No
Do you have a VA service-connected disability rating and are receiving VA compensation? □ Yes □ No If yes, what % _____
For what condition(s) _____
VA Claim # _____ Did you serve in combat after 11/11/1998? □ Yes □ No
Do you need assistance in applying for or increasing a VA service-connected disability rating? □ Yes □ No
Are you receiving DoD/military disability retirement pay? □ Yes □ No
Do you need care of conditions potentially related to service in SW Asia? □ Yes □ No
Are you represented by a Veterans Service Officer/Benefits Counselor? □ Yes □ No
Name: _____ Phone #: (_____)_____
Was your discharge from the military for a disability incurred or aggravated in the line of duty? □ Yes □ No

Section 4 – FINANCIAL, EMPLOYMENT & EDUCATION

Please estimate your monthly income at the time you are accepted into this program: $_____

Please check all expected sources of monthly income that apply to you and provide the current monthly amounts from the resources below:

□ FT/PT Employment	$_____	□ Unemployment Benefits	$_____
□ VA Svc. Connected Disability	$_____	□ VA Non-Svc/Pension	$_____
□ DoD Disability	$_____	□ Ed Benefits/GI Bill	$_____
□ Social Security Disability	$_____	□ Social Security Retirement	$_____
□ Other (list): _____	$_____		

Are you enrolled or planning to enroll in college? □ Yes □ No
Are you enrolled or planning to enroll in a job/technical skills training program? □ Yes □ No
Have you applied for any VA educational assistance programs? □ Yes □ No □ Not Sure

Employment: Are you currently employed? □ Yes □ No
□ Full-time □ Part-time
Name of Employer: _____
Address: _____
_____
Phone #: ( ) _____
If you are not currently working, are you receiving or have you applied for unemployment benefits? □ Yes □ No
Have you met with a CT Dept. of Labor veterans' employment counselor? □ Yes □ No

Name _____ **Last 4 Digits of Social Security #** _____

Section 5 – CONSERVATORSHIP/POWER OF ATTORNEY

Do you have a Power of Attorney? ☐ Yes ☐ No (complete information below - enclose a copy of decree)

Is this Appointment for: ☐ Person ☐ Estate ☐ Both Effective date _____

Do you have someone appointed as your Conservator? ☐ Yes ☐ No (complete information below - enclose a copy of decree)

Is this Appointment for: ☐ Person ☐ Estate ☐ Both Effective date _____

If NO to either of the above, go directly to Section 6

POWER OF ATTORNEY		**CONSERVATOR**	
Name		Name	
Relationship		Relationship	
Street		Street	
Apartment #		Apartment #	
City		City	
State	Zip	State	Zip
Home Phone	( )	Home Phone	( )
Work Phone	( )	Work Phone	( )
Cell Phone	( )	Cell Phone	( )
Fax #		Fax #	
Email Address		Email Address	

Section 6 – INSURANCE INFORMATION

Are you enrolled in the VA CT Healthcare System? ☐ Yes ☐ No ☐ Not Sure

Are you covered by any other health insurance policies? (including coverage through a spouse, parent or another person)

☐ Yes ☐ No (If yes, please complete policy information below)

Name of Policy Holder: _____ Policy Number: _____

Group Code: _____

Health Insurance Company's Name, Address (Street, City, State, Zip), and Telephone Number:

_____

_____

Please list the name of your Primary Care Physician, where he/she practices and the telephone number (if known):

Name of Primary Care Physician: _____

Facility/Practice of Primary Care Physician: _____

Telephone Number: _____

Are you fully ambulatory and able to care for yourself in an independent residential setting? ☐ Yes ☐ No

Medical History: Is there anything about your physical or behavioral health that would prevent you from living successfully with other OEF/OIF veterans in an independent residential setting? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Name _____ **Last 4 Digits of Social Security #** _____

Section 7 – MEDICAL INFORMATION

PLEASE ANSWER ALL QUESTIONS BELOW.

Where do you go now for your medical care?		
Have you been hospitalized in the past 5 years? If yes, when, where, and for what reason.	**Yes**	**No**
Do you have any difficultly ambulating (walking) ? If yes, please explain.		
Do you require any assistive equipment to ambulate (walk independently)? If yes, check below: ☐ Cane ☐ Walker ☐ Crutches		
Are you being treated for/or in need of any of the following? ☐ Heart/Blood Pressure ☐ Tuberculosis (TB) ☐ Kidney ☐ Pulmonary (difficulty breathing) ☐ Diabetes ☐ Seizures ☐ Liver ☐ Traumatic Brain Injury (TBI) ☐ Sleep disorder ☐ Memory Problems ☐ Other - please explain:		

Section 8 – MENTAL HEALTH INFORMATION

Have you ever been told that you have Post Traumatic Stress Disorder (PTSD)? If yes, please explain.	**Yes**	**No**
Have you or someone close to you recognized any difficulty managing your anger? If yes, please explain.		
Have you recently had or have had a history of feeling low, feeling down, or feeling depressed? If yes, please explain.		
Have you had any problems with anxiety, obsessive compulsive disorder, panic attacks? If yes, please explain.		
Have you ever felt like harming yourself? If yes, please explain.		

Name _____ **Last 4 Digits of Social Security #** _____

Section 9 – MEDICATIONS

What medications do you take or should you be taking?	Dose	How often do you take this medication?

Section 10 – RECOVERY SUPPORT

Please answer all questions below.	Yes	No
Have you ever taken drugs or alcohol or been told that you have a substance abuse problem? If yes, please explain.		
Have you ever attended a program for drug or alcohol abuse? If yes, when and where?		
Are you attending a substance abuse program now? When did you start? When will you complete it? Where is it located?		
Are you interested in participating in our Recovery Support Services to assist you with your ongoing substance abuse recovery?		

If you receive your care from the VA Connecticut Healthcare System, the name and signature of your Primary Care Physician is required.

"This person will continue to be eligible for care within the VA Connecticut Healthcare System"

Printed Name of Primary Care Provider	Signature of Primary Care Provider	Date
_____	_____	

RELEASE OF INFORMATION

Veteran's Name _____ Date of Birth _____/_____/_____

Social Security Number _____-_____-_____ VA Claim Number _____

I HEREBY AUTHORIZE THE STATE OF CONNECTICUT, DEPARTMENT OF VETERANS' AFFAIRS, TO OBTAIN INFORMATION FROM:

1. VA Connecticut Medical Centers, Newington and West Haven, CT
2. US VA Regional Office, Newington, CT
3. Other Treatment Facilities (List)

_____

INFORMATION TO BE DISCLOSED: (Initial each item that applies):

_____ Copy of complete health records including outpatient, E.R., hospitalization
_____ Alcohol Abuse
_____ Drug Abuse
_____ Psychiatric
_____ Sickle Cell
_____ On-going communication (telephonic/written/faxed)
_____ Military Service

I authorize the Connecticut Department of Veterans' Affairs to release/obtain all pertinent information regarding my treatment which may include information relating to medical, psychiatric, alcohol, and drug abuse, HIV/AIDS, and Sickle Cell to/from such facilities as necessary for the admissions process and any treatment and care.
For release of information, this authorization will automatically expire ninety (90) days from the date below.
This facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized therein.
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and 38CFR) and/or state law. The Federal rules and/or state law prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42CFR Part 2 and/or state law. A general authorization for the release of medical or other information is NOT sufficient information to criminally investigate or prosecute any alcohol or drug abuse patient.

X_____ Date _____
Signature of Veteran or Conservator of Person

Serving Those Who Served
Connecticut Department of Veterans' Affairs

Name:_____ Last 4 Digits of Social Security # _____

Billing/DVA Cost of Care Information

PATRIOTS' LANDING (PL)
OEF/OIF TRANSITIONAL ASSISTANCE HOUSING PROGRAM FEES:

PL is a six month program with a possible six month extension if needed. The cost of care is determined by the length of stay. However, in extreme financial hardship, the Department of Veterans' Affairs will waive the cost of care for veterans who complete the agency waiver form and provide proper documentation verifying an income hardship.

LEVEL:	Length of Stay	**Monthly Billing Rate**
1	**0 to 3 months**	**$0.00**
2	**4 to 36 months (3 years)**	**$200.00**

If you have any questions regarding the program, please contact:

Maria Cheney – Director of Residential Programs & Services – (860) 616-3801
Thomas Stefanko – Manager of Advocacy & Assistance – (860) 616-3683

If you have any questions regarding billing or billing exceptions, please contact:

Elizabeth Syska – Fiscal Administrative Supervisor (860) 616-3644
Linda Turgeon – Fiscal Administrative Officer (860) 616-3645
Susan Anderson - Fiscal Administrative Officer (860) 616-3646

The monthly payment is due on the 15th of every month. All checks should be made payable to CT Department of Veterans' Affairs and can be paid at the Billing Satellite Office located at the Domicile/ E Wing. The satellite office hours are Monday & Wednesday 8:00am – 12:00pm and Friday 8:00am to 3:00pm. Payment can also be mailed to Billing Office at 287 West Street, Rocky Hill, CT 06067. *Note: The billing statement is billed one month in arrears.*

Not complying with the monthly program fee will constitute disenrollment from the program.

I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED ON THIS FORM AND UNDERSTAND THE CONTENTS.

_____ _____
Signature of Veteran or Financial Representative *Date*

_____ _____
Maria Cheney, Director of Residential Programs & Services *Date*

Connecticut Department of Veterans' Affairs
PATRIOTS' LANDING
OEF/OIF Transitional Assistance Housing Program
Billing Exception Request Form

VETERAN INFORMATION: *(To be completed by resident)* **DVA Case #**

RESIDENT NAME:		
Please Print:	***Last Name***	***First Name***
EXCEPTION REQUEST FOR MONTH/YEAR:		

CIRCUMSTANCES: *(To be completed by resident)*

Income Sources: *(Please check all that apply and list amount received and any additional sources):*

☐ VA Educational Stipend $	☐ Social Security $	☐ VA Service Connected $
☐ VA Pension $	☐ Private Pension $	☐ DVA Payroll $
☐ DVA Detail $	☐ Other (List)_____$	☐ Other _____$

Resident Signature:	**Date:**

-Please do not write below this line-

BILLING OFFICE REVIEW:

EXCEPTION AUTHORIZATION:

☐ **Approve** ☐ **Deny - Sufficient Income to Pay**

Reviewer:	**Date:**
Approved by:	**Date:**

CC: Fiscal Administrative Manager *Residential Programs & Services Director* Billing Office (Revised 6/11)